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INSURE THE UNINSURED PROJECT

ITUP Draft Summary Of California's §1115 Medicaid Waiver

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The recently approved federal waiver does four things:

1) Funds coverage for medically indigent adults (MIAs) and other low income adults in county programs (Low Income Health Program)
2) Moves some seniors and persons with disabilities into managed care and better coordinates the care of children in the California Children's Services (CCS) program
3) Funds a variety of state programs for the uninsured and public providers' uncompensated care
4) Funds the evolution of public hospitals into models of coverage.

Low Income Health Program for MIAs and Other Uninsured Adults

The Low Income Health Program consists of two programs: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE is uncapped and is intended for persons with incomes of less than 133% of FPL. HCCI is for persons with incomes between 133 and 200% of FPL and expenditures fall within the safety care pool funding cap. The entire program is at county option.

1) County match is through local certified public expenditures (CPEs) on the eligible population.
2) Only US citizens and legal permanent residents are eligible. The county determines eligibility and sets its own income eligibility standards.
3) Counties must maintain their 2006 levels of financial effort.
4) Counties can set enrollment caps and wait lists if their program expenditures exceed allocations.
    a. MCE eligibles must have absolute priority over HCCI eligibles. In other words before a county can cap program enrollment for MCE eligibles, it must first cap enrollment for HCCI eligibles.
5) Counties may offer up to three months of retroactive eligibility if they so choose.
6) Counties must offer a core set of benefits:
    a. Inpatient, outpatient and emergency hospital services
    b. Physician services
    c. Lab and x-ray services
    d. Prescription drugs, medical equipment and supplies, prosthetic and orthotic appliances and devices
    e. Podiatric care
    f. Mental health (for MCE eligibles only)

    Counties can offer more extensive benefits, such as adult dental care.
7) Counties must cover out of network emergency services and pay at least 30% of the applicable Medi-Cal rates
8) Counties must cover minimum mental health services that meet a defined medical severity threshold (significant impairment in life functioning or probability of significant deterioration in important life functioning).
    a. 10 days of inpatient
    b. Psychiatric pharmaceuticals
    c. 12 outpatient visits annually
9) Cost sharing must comply with Medicaid rules

10) Managed care systems (including a closed panel county delivery system) must comply with federal rules governing MCOs.
11) Timeliness of care: Primary care appointments must be within 30 business days of request for the first year of the waiver and 20 business days of request in the second and subsequent years. Urgent care appointments must be within 48 hours of request. Specialty care services must be within 30 business days of request.
12) Freedom of choice: Enrollees must have a choice of at least two primary care providers and the right to request a change of provider.
13) Geographic access: Access to a primary care provider must be within 30 miles or 60 minutes from the patient's address.
14) FQHCs: The County must contract with a least one FQHC.
15) Credentialing: All providers must be appropriately credentialed.
16) Counties must collect and report their spending and encounter data.
17) Payments to providers may not exceed cost as determined by federal cost reporting rules.
18) Fair hearing appeals of eligibility and benefit denials are required.
19) Los Angeles County must make cost efficient transportation services available when their hospital network provides insufficient geographic access.

Medi-Cal Managed Care for Seniors and Persons with Disabilities & Pilot Programs for California Children's Services

Seniors and persons with disabilities (SPDs) make up a small share of the Medi-Cal population, but a large proportion of Medi-Cal spending. The managed care expansion does not impact the Medi-Medis or dual eligibles, who have both Medicare and Medi-Cal coverage.

- In managed care counties, the state may require SPDs to enroll in managed care.
    - Enrollment will be on a rolling basis based on an individual's date of birth over a twelve-month period beginning June 1, 2011.
    - Default enrollment shall be linked to the beneficiaries' prior use of particular providers.
    - Beneficiaries have a right to change enrollment annually or for cause during the plan year.
    - Beneficiaries have a choice of at least two plans, except in COHS (County Organized Health System) counties.
- There must be an outreach and communication strategy to explain this change in advance and on an ongoing basis.
- The plan networks must be adequate to provide access to all covered services, including prevention, primary and specialty care, in reasonable geographic proximity.
- Networks must be culturally competent for the populations covered
- Enrollees with special health care needs must have direct access to a specialist appropriate to the individual's condition.
- Plans must have in place: care coordination and continuity of care, timely and standardized assessments of an individual's medical needs, person-centered planning and treatment, discharge planning, linkages to health information technology, and monthly submissions of accurate encounter data.

Many California Children's Services (CCS) children are enrolled partially in managed care and partially in fee-for-service through the CCS program. Under the waiver, CCS children may be enrolled into one of four pilot programs developed by the state and local partners to improve care coordination, patient satisfaction and effectiveness of the programs. The state must give six months notice and secure federal approval of the particulars of the four proposed pilots.

1. Enhanced primary care case management

2. Provider-based accountable care organization
3. Specialty health care plan
4. Existing managed care plan.

Safety Net Care Pool Funding: State Programs, Providers' Uncompensated Care and the Evolution of Public Hospitals Towards Coverage Models

The waiver provides federal matching funds through the Safety Net Care Pool (SNCP) for state funds spent on the following state programs' care for the uninsured:

- Breast Cancer And Cervical Cancer Screening And Treatment
- Medically Indigent Adult Long Term Care
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Expanded Access to Primary Care Program
- AIDS Drug Assistance Program
- Department Of Developmental Services

SNCP funds cannot be spent on non-emergency care to the undocumented or new legal permanent residents. As a result 13.95% of expenditures are treated as funds spent on non-emergency care to the undocumented and new legal permanent residents; however the state can show a lower or no disqualified expenditure on any of the above programs other than CCS and GHPP. The federal SNCP funds for state programs are capped at $400 million annually ($2 billion over 5 years).

Provider counties with public hospitals can receive funds through the Delivery System Reform Incentive Pool. The purpose of these SNCP funds is to prepare the public systems to participate in coverage opportunities under the federal reforms. Over the next five years, $6.5 billion is allocated for the following:

- Infrastructure Development: information technology, primary care or telemedicine
- Innovation and Redesign: medical homes and disease management
- Population Focused Improvement: diabetes care management, chronic disease care management, improving healthy eating and other healthy behaviors for high risk populations
- Urgent Improvement in Care: top level performance on two or three hospital-based interventions.

Initial and future funding is tied to demonstrable progress on measurable outcomes. Each public hospital system must submit its plan for approval within 60 days of the waiver's approval. Public hospitals can provide the match for these funds with IGTs (Intergovernmental Transfers).

SNCP funding for uncompensated care is $3.9 billion over five years. SNCP payments for uncompensated care can be made for care to the uninsured in hospital, clinic or other provider settings. This includes the state programs referenced above.

- The match is through Certified Public Expenditures (CPE). The match can be provided by government-operated hospitals, the state, a county, a city and can include a district hospital or University of California hospital.
- SNCP funds cannot be used for non-emergency care to the new legal permanent residents and the undocumented. A discount of 13.95% is assumed to be non-emergency care to new legal permanent residents and the undocumented.